SUPREME COURT, U. S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-871

NEW JERSEY CHAPTER INCORPORATED OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, INC., *Petitioner,*

v.

THE PRUDENTIAL LIFE INSURANCE COMPANY OF AMERICA *et al., Respondents.*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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No.

NEW JERSEY CHAPTER INCORPORATED OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, INC., *Petitioner,*

v.

THE PRUDENTIAL LIFE INSURANCE COMPANY OF AMERICA *et al., Respondents.*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Petitioner prays that a writ of certiorari issue to review the judgment of the United States court of appeals for the District of Columbia Circuit entered in the above case.

I. OPINIONS BELOW

The opinion of the United States district court for the District of Columbia (App. A, beginning on p. 1a) has not been reported.

The opinion of the court of appeals for the District of Columbia Circuit (App. B, beginning on p. 2a) is reported at 502 F.2d 500.

II. JURISDICTION

The judgment of the court of appeals for the District of Columbia Circuit (App. C, p. 12a) was entered on September 6, 1974. That court's order denying the petition for a rehearing (App. D, p. 13a) was entered on October 17, 1974. The jurisdiction of the Supreme Court is invoked under 28 U.S.C. § 1254(1).

III. QUESTIONS PRESENTED

Under the Medicare program, eligible beneficiaries may receive physical therapy services at hospitals or other providers of services. The Department of Health, Education and Welfare (HEW) will reimburse providers for the "reasonable cost" of such services including the reasonable cost of services performed by independent physical therapists.

In New Jersey payments to providers for the reasonable cost of such services are made through The Prudential Insurance Company of America (Prudential), acting as a fiscal intermediary under an agreement with HEW and performing administrative functions which the Medicare Act specifically authorizes and prescribes. Under the Act the Secretary of HEW is to promulgate regulations establishing the method to be used in determining the reasonable cost of any service. Until the end of 1971 Prudential made payments to providers for the reasonable cost of services by applying HEW regulations, which essentially provide for paying "actual costs" unless those costs "are found to be substantially out of line with other institutions in the same area which are similar . . . ."

Beginning in 1972, Prudential issued its own standard for determining the reasonable cost of physical therapy services performed by independent therapists.

Under Prudential's standard, reimbursements for services by independent therapists could "not exceed an amount equal to the salary which would have been payable if the services had been performed by an employee therapist" (plus certain expenses), regardless of the actual cost incurred—the so-called "salary-equivalence standard."

Presented for review are the following questions:

1. Whether Prudential's salary-equivalence standard must be declared unlawful, and its operation enjoined:

(a) because it constitutes a method of determining the reasonable cost of physical therapy services which the Medicare Act requires be established by the Secretary of HEW as a regulation; and

(b) because its issuance by a fiscal intermediary was beyond the authority granted such intermediary by the Act.

2. Whether the court of appeals, in deciding this case on the merits, erred by assuming facts as to the nature and effect of Prudential's salary-equivalence standard, which facts are in dispute by the parties and crucial to proper adjudication of the issue in question.

IV. STATUTES AND REGULATIONS INVOLVED

Various sections of the Medicare Act (technically the Health Insurance for the Aged Act, 42 U.S.C. §§ 1395 *et. seq.* (1970)),[1] HEW regulations thereunder

[1] All citations herein to sections of the Medicare Act are to its 1970 codification in U.S.C., which version governs the issues presented here. Congress amended some of these sections in 1972. Pub. L. No. 92-603. *See* pp. 14-15, *infra*.

(20 C.F.R. §§ 405.401, 405.451), and the Administrative Procedure Act (5 U.S.C. § 501 *et seq.*) are involved here and are set forth in App. E, p. 14a.

V. STATEMENT OF THE CASE

A. The Medicare Act—A Conspectus

The Act "provides basic protection against the costs of hospital and related post-hospital services . . . for individuals who are age 65 or over" and are entitled to benefits under the Act. 42 U.S.C. § 1395c. Beneficiaries are entitled to receive services covered by the Act from hospitals, extended care facilities, or home health agencies qualified to participate in the program. Such institutions are called "providers of services" or "providers." 42 U.S.C. § 1395x(u); 42 U.S.C. § 1395cc.

Beneficiaries need not compensate providers for program benefits received. Instead, providers are entitled to be reimbursed with program funds for the "reasonable cost" of the services they provide to beneficiaries. 42 U.S.C. § 1395f. Payments of the amounts owing for services may be made through a private organization acting as a "fiscal intermediary." Section 1395x(v)(1) states that the "reasonable cost of any services shall be determined in accordance with regulations establishing the method . . . to be used . . . in determining such [reasonable] costs." Under section 1395hh these regulations must be issued by the Secretary of HEW.

The Act provides coverage for physical therapy services rendered to a beneficiary at a provider's facility. 42 U.S.C. §§ 1395d, 1395k. Reimbursement for physical therapy services performed under the Act shall be the "reasonable cost" of those services. 42 U.S.C. §§ 1395f(b), 1395l(a). The "reasonable cost" basis for

reimbursement shall be determined in accord with section 1395x(v), which, as explained above, requires that "methods" for making determinations of reasonable cost be established by regulations promulgated by the Secretary of HEW.

B. HEW's Pertinent Regulation

The Secretary has issued regulations for determining the reasonable cost of services, providing in part (20 C.F.R. § 405.451(c)(2)) that:

> "The provision in Title XVIII of the Act [section 1395f(b)] for payment of *reasonable cost of* services is intended to meet the *actual costs however widely they may vary from one institution to another.* This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors." (Emphasis added.)

This regulation is the basis upon which independent physical therapists and providers have established the reasonable cost of physical therapy services performed under the Medicare Act from its inception until January 1, 1972.

Although the foregoing regulatory language has not been amended and remains in full force and effect, HEW's Bureau of Health Insurance (BHI) has sought on at least two occasions relevant here to embellish it.[2] In August 1969 BHI issued "Intermediary

[2] Another amendment to this section (37 Fed. Reg. 10354 (May 20, 1972)) left this language unchanged and is not relevant to this case.

Letter No. 393," detailing the "prudent buyer" concept and providing in part:

> ". . . This letter outlines some of the steps which [fiscal] intermediaries should be taking to protect the program against making reimbursement for amounts which are in excess of what a prudent and cost-conscious buyer would pay for a given item or service.
>
> "The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to minimize cost . . . ."

In October 1971 BHI sent to all intermediaries a draft of another *proposed* intermediary letter which sought to introduce the salary-equivalence concept. It stated:

> "This letter establishes guidelines for intermediaries to follow in determining the reasonableness of the costs a provider incurs in furnishing physical, occupational, inhalation or speech therapy to program beneficiaries under arrangements with self-employed therapists. The basic measure of reasonable cost for the service of nonemployee therapists is the amount of salary or wages that is paid to employee therapists in the area performing similar functions and is intended to protect the program against reimbursing for costs in excess of what a prudent and cost-conscious buyer would pay for the services. This amount is adjusted to take into account the normal fringe benefits of full-time employees of the provider, as well as reasonable expenses incurred by a part-time nonemployee therapist."

BHI intended this proposal to be based on the "prudent buyer" concept:

> "Providers are expected to be prudent and cost-conscious purchasers of arranged-for therapy ser-

> vices. In applying this concept, the following situations are presumptively indicative of unreasonable costs: (1) costs incurred for the services of an independent contractor are in excess of what would have been the provider's costs of furnishing the same services had it employed a therapist. . . ."

This proposal was neither published in the Federal Register as required by the Administrative Procedure Act nor was it ever finalized. In fact, the "prudent buyer" concept itself has never been promulgated formally as a regulation. Consequently, HEW's reasonable cost regulation quoted above (20 C.F.R. § 405.451 (c)(2)) remains the only formally promulgated regulation on the method of determining reasonable cost.

C. Prudential's Salary-Equivalence Standard

On November 23, 1971, Prudential, acting in its role as fiscal intermediary, sent a letter to extended care facilities setting forth a salary-equivalence standard which it apparently developed and promulgated on its own initiative, with "the effective date of January 1, 1972." This letter specifically provided that:

> "1. Payment for the cost of these services [*i.e.*, physical, speech, occupational, and inhalation therapy services rendered by non-salaried therapists in an institutional setting] shall not exceed an amount equal to the salary which would have been payable if the services had been performed by an employee, plus the cost of such other reasonable expenses as may be incurred by independently contracting therapists (*e.g.*, travel time, salaries of aides).
>
> "2. Payment for the cost of these services will be based upon the reasonable time spent in performing them."

In further elaboration of this new standard Prudential's letter stated that "allowable reimbursement for the services of therapists is to be based on a salary-equivalent," and "[*o*]*ur measurement* of the reasonableness of these services will be based on hourly rates of pay . . . ." (Emphasis in original.)

Subsequently, on April 12, 1972, Prudential issued a second letter, said to have been intended "to clarify" Prudential's salary-equivalence standard, which stated in part:

> "It should be noted that our previous letter indicated the establishment of guideline criteria for evaluating the reasonableness of the cost of therapy services and was not intended as a maximum for payment. Providers incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost. However, the burden of proof of the reasonableness of the costs does lie with the provider."

Since January 1, 1972 Prudential has been making its reasonable-cost determinations regarding therapy services by independent practitioners by applying this salary-equivalence standard.

D. Petitioner

Petitioner, the New Jersey Chapter Incorporated of the American Physical Therapy Association, is plaintiff in this action. Petitioner, a New Jersey corporation, is an association composed of physical therapists licensed to practice physical therapy in New Jersey. Many of petitioner's members are independent practitioners who provide therapy services to Medicare beneficiaries under contractual arrangements with providers.

E. Summary of This Litigation

1. Petitioner's Action

Petitioner commenced this action on March 3, 1972 in the district court for the District of Columbia naming as defendants Prudential, the Secretary of HEW, the Commissioner of the Social Security Administration, and the Director of BHI. Petitioner seeks a declaratory judgment that Prudential's salary-equivalence standard is unauthorized and contrary to law, plus injunctive and other relief.

2. Jurisdiction of the District Court

Petitioner's action arises under the Medicare Act and the Administrative Procedure Act. Jurisdiction in the district court was founded upon 28 U.S.C. §§ 1331, 2201-02, and 5 U.S.C. §§ 702 *et seq.*, venue upon 28 U.S.C. § 1391(e).

3. Decisions Below

The district court dismissed the complaint "for lack of plaintiff's standing." The district court's brief opinion made no findings of fact on any issue going to the merits.

The court of appeals affirmed the judgment of dismissal, not on the ground of standing but "on the merits."[3] In making its decision, as we set forth

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[3] Judge Robb's opinion of September 6, 1974 stated that in light of the court's view of "the merits," the court would not "pause to wrestle" with the "close and difficult questions" of standing and reviewability. Chief Judge Bazelon's concurring opinion of October 3, 1974 stated that he "cannot agree . . . with the suggestion" of Judge Robb "that the current law on standing and reviewability has gone too far or that the law, as applied in this case, presents 'close and difficult questions.'"

below, the court of appeals adopted, assumed, or found "facts" which the district court had not even considered much less found to be true, which ran contrary to the allegations of petitioner's complaint, and which the parties have disputed.

4. Petitioner's Contentions on the Merits

a. Prudential's Salary-Equivalence Standard Constitutes a Method of Determining Reasonable Cost Which the Medicare Act Requires To Be Established by the Secretary of HEW as a Regulation.

The Medicare Act explicitly provides:

> "The amount paid to any provider of services with respect to services for which payment may be made under this part shall . . . be the reasonable cost of such services, as determined under section 1395x(v) of this title." (42 U.S.C. § 1395f(b).)
>
> "The *reasonable cost* of any services *shall be determined in accordance with regulations establishing the method or methods to be used*, and the items to be included, *in determining such costs* for various types or classes of institutions, agencies, and services . . . ." (*Id.* § 1395x(v)(1).) (Emphasis supplied.)
>
> "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary." (*Id.* § 1395hh.)

Since Prudential's salary-equivalence standard established "the method . . . to be used . . . in determining such [reasonable] costs," it had to be

established by the Secretary as a regulation.[4] Required, then, was adherence not only to the procedural guarantees of the Administrative Procedure Act (5 U.S.C. § 553), but also to the additional procedural protections of the Medicare Act itself.[5] Having been issued "without observance of procedure required by law," Prudential's salary-equivalence standard must be held "unlawful and set aside." 5 U.S.C. § 706(2)(D).

b. Prudential, as a Fiscal Intermediary, Had No Authority to Issue the Salary-Equivalence Standard.

The Medicare Act specifies what functions Prudential, or any other intermediary under contract with HEW, may provide. 42 U.S.C. § 1395h. The statute does not authorize Prudential to issue any regulation, *or* prospectively to establish a "method . . . to be used . . . in determining" reasonable cost, *or* even to issue prospective "interpretations" or "guidelines." Whether the salary-equivalence standard is a regulation, method, interpretation, or guideline, it was beyond Prudential's authority to issue it.

---

[4] Even if Prudential's actions were viewed as only fixing the burden of proof, it would nevertheless be a method for establishing reasonable cost which would have to be prescribed by the Secretary as a regulation.

[5] Thus, section 1395x(v)(1) provides in part:

> ". . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers . . . ."

The Medicare Act envisioned a three-step process:

> *First,* Congress declares the principle of payment—"[t]he amount paid . . . shall . . . be the reasonable cost . . . ." 42 U.S.C. § 1395f(b), *restated in* 20 C.F.R. §§ 405.401(a), 405.451(a).
>
> *Second,* the Secretary of HEW sets the "method . . . to be used . . . in determining" payment according to this congressional principle. 42 U.S.C. § 1395x(v)(1). *See also id.* § 1395hh; 20 C.F.R. § 405.451(b), (e).
>
> *Third,* applying the Secretary's formula or "method," Prudential the fiscal intermediary makes the administrative "determination" of the proper amount. 42 U.S.C. § 1395h; 20 C.F.R. § 405.401(b).

Prudential's attempt to establish the "method . . . to be used . . . in determining" reasonable cost must fall as *ultra vires.* Even if Prudential were an official agency of government, it could not exercise power Congress did not grant to it. *Oestereich* v. *Selective Service System Local Board No. 11,* 393 U.S. 233 (1968); *Citizens Committee for the Hudson Valley v. Volpe,* 425 F.2d 97, 102 (2d Cir. 1970). *A fortiori,* acting under contract as HEW's agent to help carry out a government program (42 U.S.C. § 1395h), Prudential cannot exercize a policy function beyond its legislative authorization. *See Fletcher v. Housing Authority of Louisville,* 491 F.2d 793, 798-99 (6th Cir. 1974).

c. The Court of Appeals Made Impermissible Findings or Assumptions of Fact and as a Result Reached an Erroneous View of the Nature and Effect of Prudential's Salary-Equivalence Standard.

The court of appeals decision includes the following points:

> "We think this letter was a reasonable and proper attempt to outline a rational method for determining 'reasonable costs.'"
>
> "Prudential's letter was not a regulation but was merely an explanation or interpretation of the reasonable cost limitation found in the Medicare Act."

These points are, in light of the statutory provisions discussed above, logically inconsistent. For if the salary-equivalence standard was a "method for determining 'reasonable costs,'" it had to have been established as a regulation by the Secretary, or else it should have been declared unlawful by the court. However, the court of appeals accepted the defendants' characterization of the salary-equivalence standard as "merely an explanation or interpretation" or "guideline" which does not set a "ceiling" on reimburseable costs, ignoring the fact that the nature and effect of the standard constitute the principal factual issue in the case.

In truth, whether the standard sets a "ceiling" on costs is irrelevant. Characterizing the salary-equivalence standard as a mere "guideline," "explanation," or "interpretation" is also irrelevant, although the characterization clouds the issue by making Prudential's action seem less significant than it really is.

As long as one recognizes that the salary-equivalence standard is a "method . . . to be used . . . in determining" reasonable cost, one must conclude that its issuance by Prudential was unlawful.

Part VI. B, *infra*, of this petition explains in detail how the court of appeals' acceptance of a particular view of the facts was impermissible.

VI. REASONS FOR GRANTING THE WRIT

A. The Court of Appeals Has Erroneously Decided Important Questions of Federal Law Which Have Not Been But Should Be Settled By the Supreme Court

The provisions of the Medicare Act involved here deal with the amounts of Medicare reimbusements. Proper and lawful determination of such amounts will affect the quantity and quality of services available to Medicare beneficiaries because such amounts constitute the only compensation and economic incentive for therapists or other professionals to participate in the program.

Congress specifically required that the method for determining reimbursable cost, a crucial aspect of Medicare reimbursement policy, be set by the Secretary in regulations and intended that HEW maintain control over the crucial aspects of the program for which it bears responsibility. The court of appeals decision permits Prudential, a fiscal intermediary, to assume a key function of an official government agency, and beyond that permits the fiscal intermediary to do so by simply writing a letter.

The specific provision of the Medicare Act at issue here (42 U.S.C. § 1395x(v)) has been amended since the filing of this action, by the addition of a congressional salary-equivalence standard. *See* fn. 1, p. 3,

supra. There has been no suggestion that this moots the present action, since reimbursement is still being made under Prudential's standard. In addition, it does not make the case any less important for review by the Supreme Court, since the issue here goes beyond that of reimbursements for therapists and indeed involves basic questions as to the scope of authority to be granted to fiscal intermediaries.

If fiscal intermediaries can usurp the statutory authority of the Secretary of HEW to establish, by regulation, methods of determining therapy-cost reimbursements, fiscal intermediaries may well reach for other government functions which Congress did not intend to, or could not constitutionally, permit private companies to exercise—*e.g.*, establishing methods of determining the reasonable cost of the services of other professionals, deciding eligibility for Medicare benefits, or determining the conditions under which providers may participate in Medicare programs. The fact that HEW will allow a fiscal intermediary to assume this authority in one area raises a serious question whether it is abandoning its legal responsibility. The fact that HEW and Prudential have so far taken just one step over the boundary must not cloud one's judgment of that step's seriousness. For, as Mr. Justice Frankfurter reminded all of us: "The accretion of dangerous power does not come in a day. It does come, however slowly, from the generative force of unchecked disregard of the restrictions that fence in even the most disinterested assertion of authority." *Youngstown Sheet and Tube Co. v. Sawyer*, 343 U.S. 579, 593 (1952).

B. The Court of Appeals Assumption or Finding of "Facts" Which the District Court Had Not Found To Be True, Which Ran Contrary to the Allegations of Petitioner's Complaint, and Which the Parties Have Sharply Disputed So Far Departs From the Accepted and Usual Course of Judicial Proceedings as To Call for an Exercise of the Supreme Court's Power of Supervision

The court of appeals stated that "it is plain to us that Prudential will continue to allow all costs that are reasonable." The court of appeals thereby accepted the self-serving statement in Prudential's so-called clarifying letter of April 12, 1972 that "[p]roviders incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost." "In other words," said the court, "the guidelines establish a level of costs which Prudential will pay without additional proof of their reasonableness."

If one treats the court of appeals decision as a dismissal of the complaint for failure to state a claim, then "the allegations of the complaint and supporting affidavits [must be accepted] as true." *Gardner v. Toilet Goods Ass'n*, 387 U.S. 167, 172 (1967). Assertions of fact inconsistent with allegations in the complaint must be disregarded.

The court of appeals decision ignores this principle. The facts said to be "plain to" that court are directly contrary to petitioner's allegations. Specifically, the complaint sets forth the language of Prudential's September 23, 1971 letter which stated flatly: "Payment for the cost of these services *shall not exceed* an amount equal to the salary . . . [of] an employee, plus reasonable expenses. . . ." (Emphasis added.) The complaint also pointed out that Prudential had created a "scale of hourly rates" for reimbursements

for independent physical therapists, and that "BHI approved the sliding scale and instructed Prudential to make the scale effective." The complaint also alleged that "the hourly scale will cut approximately in half" the level of reimbursements that had been paid before January 1, 1972. The complaint referred to the salary-equivalence standard as "a limit on the reasonable cost of non-salaried physical therapist services" which "contravenes the expressed intent of Congress to allow for flexibility . . . and to reimburse providers . . . for their actual cost however widely they may vary from one institution to another." As petitioner has demonstrated, the nature and effect of Prudential's standard are viewed by petitioner as constituting the crucial factual issue in the case.

If, on the other hand, the court of appeals decision is treated as a grant of summary judgment to defendants, its action is equally irresponsible. In that case, if material facts are genuinely at issue, the motion for summary judgment must be denied—"[f]actual issues are not to be tried or resolved by summary judgment procedure. . . ." *Dewey v. Clark*, 180 F.2d 766, 772 (D.C. Cir. 1950). These principles of law the court of appeals completely overlooked. For the same "facts" said to be "plain to" that court and summarized above were sharply disputed by the parties.

This should have been obvious from the "Plaintiff's Statement of Material Facts as to which Plaintiff Contends There is a Genuine Issue" which was included in the record before the court of appeals (hereinafter referred to as the "Plaintiff's Statement"). Specifically, defendants contended that Prudential's letter set forth mere "guidelines," whereas the Plaintiff's

Statement heralded its status as a "rule" or "regulation." Defendants contended that Prudential's salary-equivalence standard "did not place a limit on the amount of reimbursement," whereas the Plaintiff's Statement reiterated and elaborated the complaint's allegations to the contrary, saying that "the practical effect . . . will be to place a limit . . .," that "overcoming the sliding scale will present a difficult burden of proof for providers and, therefore, the application of the sliding scale will be the norm."

The court of appeals, by assuming the facts in defendants' favor here has in effect denied petitioner its opportunity to prove a case well pleaded. In that regard its treatment of the factual issues is a perversion of the accepted and usual course of judicial proceedings. This calls for an exercise of the Supreme Court's power of supervision, in order to protect the integrity of the adjudicative process.

CONCLUSION

For the foregoing reasons, the writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil No. 547-72

NEW JERSEY INCORPORATED OF THE AMERICAN PHYSICAL THERAPY ASSN., INC.

v.

THE PRUDENTIAL LIFE INSURANCE CO., ET AL.

Order

This cause is before the Court on defendant's motion to dismiss or, in the alternative, for summary judgment and plaintiff's motion for summary judgment. Having considered both motions and the memoranda submitted in support and opposition thereto, the Court concludes that the complaint must be dismissed for lack of plaintiff's standing.

In order to establish its standing to bring the instant action, plaintiff must demonstrate that its interests are "arguably within the zone interests protected" by the Health Insurance for the Aged Act, 42 U.S.C. § 1395, *et seq.* *Association of Data Processing Service Organizations, Inc.* v. *Camp*, 397 U.S. 150, 153, 155-156, 90 S.Ct. 827, 25 L.Ed.2d 184 (1970). In applying this test of standing, the court must look to the intent of the statute. *See, Colligan v. Activities Club of New York, Ltd.*, 442 F.2d 686, 691 (2d Cir. 1971). The stated congressional purpose of the Act is to provide health insurance and medical care for the aged through the establishment of a compulsory hospital insurance program and a voluntary supplemental plan to furnish the aged with physicians and other health services. S.Rep. 404, 89th Cong., 1st Sess. (1965).

The Court considers that the interest of the plaintiff, an association of physical therapists, some of whom may be economically affected by the letter of instructions in dispute, is too remote to the interests protected under the Act.

Schroeder Nursing Care, Inc. v. Mutual of Omaha Insurance Co., 311 F.Supp. 405, 409 (E.D. Wisc. 1970).

Accordingly, it is by the Court this 26th day of June, 1972, ORDERED that the complaint is dismissed.

/s/ HOWARD F. CORCORAN
Judge

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 72-1789

NEW JERSEY CHAPTER INCORPORATED OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, INC., *Appellant*

v.

THE PRUDENTIAL LIFE INSURANCE COMPANY OF AMERICA, ET AL., *Appellee*

Appeal from the United States District Court for the District of Columbia

Decided September 6, 1974

Before: BAZELON, *Chief Judge*, ROBB, *Circuit Judge*, and ROBERT VAN PELT,* *United States Senior District Judge* for the District of Nebraska.

Opinion for the Court filed by *Circuit Judge* ROBB.

ROBB, *Circuit Judge:* This action arises under the Health Insurance for the Aged Act, 42 U.S.C. §§ 1395 *et seq.*, commonly known as the Medicare Act.

The Secretary of Health, Education and Welfare is charged with the administration of the Act, and he has delegated this authority to the Commissioner of the Social

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* Sitting by designation pursuant to 28 U.S.C. § 294(d).

Security Administration. Within the Social Security Administration the Bureau of Health Insurance has the primary responsibility for administering the Act. The statutory scheme "provides basic protection against the costs of hospital and related post-hospital services . . . for individuals who are age 65 or over" and are entitled to benefits under the Act. 42 U.S.C. § 1395c. Beneficiaries are entitled to receive services covered by the Act from hospitals, extended care facilities or home health agencies which are qualified to participate in the program. These institutions are called "providers of services" or providers. 42 U.S.C. § 1395x(u); 42 U.S.C. § 1395cc. They are entitled to be reimbursed for the reasonable cost of the services they provide to beneficiaries. 42 U.S.C. § 1395f. Under the Act providers may elect to have payments to them made through a private organization and the Secretary is authorized to make contractual arrangements with such an organization to act as the fiscal intermediary between the providers and the government. When this is done, the intermediary determines the amount and reasonableness of the payments to be made to providers. 42 U.S.C. § 1395h.

The appellant association, plaintiff in the District Court, is an association of physical therapists who are licensed to practice physical therapy in the State of New Jersey. Many of the association's members are private practitioners of physical therapy who have contracted to supply services to providers under the Act. Prudential Insurance Company, a defendant in the District Court, was selected by many of the qualified extended care facilities in New Jersey to serve as their fiscal intermediary, and Prudential has been acting in that capacity.

In August 1969 the Bureau of Health Insurance issued Intermediary Letter No. 393 (IL-393). This letter, captioned "SUBJECT: Identifying unreasonable costs—application of the 'prudent buyer' concept" stated in part:

Several cases have come to our attention that suggest

that it may be helpful to provide some reminders on a number of areas that involve identifying reasonable costs. This letter outlines some of the steps which intermediaries should be taking to protect the program against making reimbursement for amounts which are in excess of what a prudent and cost-conscious buyer would pay for a given item or service.

* * * *

It is not expected, for example, that reimbursement will be based on costs arising from a provider paying at individual rates for physical therapy which is provided by a single therapist to groups of patients simultaneously.

In October 1971 the Bureau sent to all intermediaries a draft of a proposed intermediary letter (IL-71). This letter stated in part:

This letter establishes guidelines for intermediaries to follow in determining the reasonableness of the costs a provider incurs in furnishing physical, occupational, inhalation or speech therapy to program beneficiaries under arrangements with self-employed therapists. The basic measure of reasonable cost for the service of nonemployee therapists is the amount of salary or wages that is paid to employee therapists in the area performing similar functions and is intended to protect the program against reimbursing for costs in excess of what a prudent and cost-conscious buyer would pay for the services. This amount is adjusted to take into account the normal fringe benefits of full-time employees of the provider, as well as reasonable expenses incurred by a part-time nonemployee therapist. Where applicable, these rules apply to other health specialists providing services under arrangements.

I. *Prudent Buyer Concept*

Providers are expected to be prudent and cost-conscious purchasers of arranged-for therapy services.

> In applying this concept, the following situations are presumptively indicative of unreasonable costs: (1) costs incurred for the services of an independent contractor are in excess of what would have been the provider's costs of furnishing the same services had it employed a therapist . . . .

A copy of the proposed IL-71 was sent to the American Physical Therapy Association on October 27, 1971 with a request that the association submit its written comments or recommendations no later than November 15, 1971. Proposed Intermediary Letter No. 71 has never been made final.

On November 23, 1971 Prudential sent to "MEDICARE PARTICIPATING EXTENDED CARE FACILITIES" a letter on the subject of "REIMBURSEMENT FOR SERVICES OF NON-SALARIED THERAPISTS." The letter stated in part:

> Public Law 89-97 provides that reimbursement to providers for covered services rendered to Medicare beneficiaries shall be on the basis of reasonable cost. In fulfilling our responsibility as an intermediary, we must identify unreasonable costs and take steps to protect the program from reimbursing for costs in excess of those which a prudent and cost-conscious buyer would incur.
>
> The implementation of this policy for physical, speech, occupational, and inhalation therapy services rendered by non-salaried therapists in an institutional setting involves two major considerations. They are:
>
> 1. Payment for the cost of these services shall not exceed an amount equal to the salary which would have been payable if the services had been performed by an employee, plus the cost of such other reasonable expenses as may be incurred by independently contracting therapists (e.g., travel time, salaries of aides).

2. Payment for the cost of these services will be based upon the reasonable time spent in performing them.

In order that this policy can be effectively carried out, it will be necessary that accurate records of the therapists' activities be maintained and made available to the intermediary. Accordingly, effective January 1, 1972, the provider will be responsible for the maintenance of a daily log showing the names of all patients treated and the total daily time spent by the therapist including time spent in the supervision of aides and/or non-qualified therapists) . . . . In the absence of a properly maintained log, no Medicare reimbursement for these therapy services will be allowed.

* * * *

Because allowable reimbursement for the services of therapists is to be based on a salary equivalent, we should know the details of your arrangements with contracting therapists. *Our measurement* of the reasonableness of the cost of these services will be based on hourly rates of pay for both the therapists and their aides, if any. . . .

In order to avoid the possibility of having a portion of your therapy costs disallowed as excessive, we strongly recommend that you negotiate arrangements with your non-salaried therapists to provide for their compensation on a time basis and that the results of such negotiations be submitted to us for review well in advance of the effective date of January 1, 1972. [emphasis in original.]

In a letter to providers dated April 12, 1972 Prudential clarified the intent of its letter of November 23. The letter of April 12, 1972 stated in part:

As you know, Intermediary Letter 393 issued on August 1969 [sic], and Provider Reimbursement Manual

section 2103, set out the concept of the prudent buyer; that is, a provider is a prudent buyer if it not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing costs. The purpose of these program statements is to assist all parties in identifying reasonable costs and to help prevent incurring unreasonable costs.

It should be noted that our previous letter indicated the establishment of guideline criteria for evaluating the reasonableness of the cost of therapy services and was not intended as a maximum for payment. Providers incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost. However, the burden of proof of the reasonableness of the costs does lie with the provider.

In March 1972 the plaintiff association commenced this action against Prudential, the Secretary of HEW, and various HEW officials. The action sought: (1) a preliminary injunction, enjoining the defendants from effectuating the standards and guidelines for reimbursement of non-salaried physical therapists as expressed in the Prudential leter and IL-71; (2) a declaratory judgment that the Prudential letter and IL-71 "are null and void"; (3) that Prudential be required retroactively to adjust any reimbursements made pursuant to its salary equivalent standard so that physical therapists who were paid in accordance with that standard would be paid in accordance with the standard prevailing prior to January 1, 1972; and (4) that Prudential be required to retract its letter because of non-compliance with the rule-making procedures of the Administrative Procedure Act.

Citing *Association of Data Processing Service Organizations, Inc. v. Camp*, 397 U.S. 150 (1970), the District Court dismissed the complaint on the ground that the interests of the plaintiff were not "arguably within the zone of interests to be protected" by the Health Insurance for the

Aged Act. The court considered that although some of the plaintiff's members might be economically affected by the Prudential letter, the plaintiff's interest was "too remote to the interests protected under the Act".

On this appeal the government argues (1) plaintiff's complaint does not state a meritorious claim for relief; (2) the District Court correctly held that plaintiff did not have standing to sue; and (3) determination of the amounts payable to providers of services is not subject to judicial review. We turn first to the government's second and third arguments.

The government says correctly that the Act was expressly designed for the protection of elderly citizens who require medical care, and those persons of course have standing to vindicate their rights under the Act. Furthermore, since the Act assures a provider of reimbursement for the reasonable costs incurred by him, a provider would seem to have an interest within the zone protected by the statute. Plaintiff's members on the other hand are not subject to regulation under the Act and their rights are derived from their contractual arrangements with providers. There is nothing in the Medicare Act or its legislative history, says the government, which indicates any concern by Congress to protect the interests of persons such as plaintiff's members who are only indirectly affected by the operation of the Medicare program. From all this the government concludes that the plaintiff and its members have no standing to sue.

In support of its argument that the plaintiff's claims are not subject to judicial review, the government directs our attention to the provisions of the Medicare Act, 42 U.S.C. § 1395ff, which provide for judicial review of (1) a determination of whether an individual is entitled to benefits and a determination of the amount of benefits, and (2) a determination that an institution is not a provider of services or that its agreement to provide services should be

terminated. The government finds it significant that no provision is made for judicial review of the award of compensation to providers of services; and the government reasons that since decisions on this matter are not subject to judicial review it follows *a fortiori* that decisions on the amounts due to contractors, who are indirectly affected by the Medicare program, are also not subject to judicial review.

There is much force in the government's arguments. As this court has said however recent decisions of the Supreme Court "have made the standing obstacle to judicial review a shadow of its former self, and have for all practical purposes deprived it of meaningful vitality." *National Automatic Laundry & Cleaning Council v. Shultz*, 143 U.S. App. D.C. 274, 278, 443 F.2d 689, 693 (1971). Standing need not be founded on a rock; a pebble or even a cobweb may do. Moreover, only a showing of clear and convincing evidence of legislative intent will justify a court in precluding access to judicial review. *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967); *Barlow v. Collins*, 397 U.S. 159 (1970). Here, we think plaintiff's standing and the reviewability of plaintiff's claims at least present close and difficult questions; but we shall not pause to wrestle with these problems, since we conclude that in any event the defendants must prevail on the merits.

The Act explicitly limits the reimbursement of "providers" to the "reasonable cost" of the services rendered to Medicare beneficiaries. 42 U.S.C. § 1395f(b). As a fiscal intermediary making reimbursement to providers, therefore, Prudential is bound to apply the reasonable cost standard to claims submitted by providers. In fulfillment of its obligation, and in accord with HEW's "prudent buyer" concept, Prudential issued its letter of November 23, 1971. We think this letter was a reasonable and proper attempt to outline a rational method for determining "reasonable costs". We think also that Pruden-

tial's use of guidelines of this type is within the authority conferred by the Act and HEW's regulations.

Although the plaintiff contends that the Prudential letter sets a "ceiling" on costs and thereby permits Prudential to disallow "reasonable costs", it is plain to us that Prudential will continue to allow all costs that are reasonable. Prudential's letter of April 12, 1972 explicitly stated:

> Providers incurring costs in excess of our guidelines will be given an opportunity to show that they were acting as prudent buyers when incurring the cost. However, the burden of proof of the reasonableness of the costs does lie with the provider.

Thus, the effect of the guidelines is to provide for automatic payment of physical therapy costs when they do not exceed the adjusted rate charged by salaried therapists; for the provider incurring such costs has clearly acted as a "prudent buyer". If the costs exceed these amounts, however, Prudential requires the provider to demonstrate that the additional costs are reasonable. In other words the guidelines establish a level of costs which Prudential will pay without additional proof of their reasonableness.

The plaintiff contends that Prudential promulgated a "regulation" without the notice and opportunity for comment required by the Administrative Procedure Act. 5 U.S.C. § 553. We think the argument has no merit. Without intimating that Prudential is an "agency" within the meaning of the Act, 5 U.S.C. § 551(1), we hold that Prudential's letter was not a regulation but was merely an explanation or interpretation of the reasonable cost limitation found in the Medicare Act. *Cf.* 5 U.S.C. § 553(b)(A).[1]

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[1] Plaintiff's complaint was filed March 22, 1972. On October 30, 1972, by amendment to the Social Security Act, Congress provided that the salary equivalent standard should apply to payments for physical therapy services. P.L. No. 92-603, 86 Stat. 1445; 42 U.S.C. § 1395x(v)(5). The plaintiff suggests that this action demonstrates that Prudential's guidelines were previously un-

The judgment is

Affirmed.

Order

[filed October 3, 1974]

It is ORDERED by the Court that the opinion filed herein on September 6, 1974 is hereby amended by attaching thereto the following statement of Chief Judge Bazelon:

> BAZELON, *Chief Judge:* I concur in the court's opinion. I cannot agree, however, with the suggestion that the current Law on standing and reviewability has gone too far or that the law, as applied in this case, presents "close and difficult questions." *See Data Processing Service Organizations, Inc. v. Camp*, 397 U.S. 150 (1970); *Barlow v. Collins*, 397 U.S. 159 (1969).

Per Curiam
For the Court

/s/ HUGH E. KLINE
Hugh E. Kline
Clerk

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authorized by the Act. We do not agree. "'Public policy requires that agencies feel free to ask legislation which will terminate or avoid adverse contentions and litigations.'" *FTC v. Dean Foods Co.*, 385 U.S. 597, 610 (1966), *citing Wong Yang Sung v. McGrath*, 339 U.S. 33, 47 (1950).

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

September Term, 1973
Civil 547-72

No. 72-1789
Filed Sep. 6, 1974
Hugh E. Kline, Clerk

New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc., *Appellant*
v.
The Prudential Life Insurance Company of America, et al., *Appellee*

Appeal from the United States District Court for the District of Columbia

Before: Bazelon, Chief Judge, Robb, Circuit Judge and Van Pelt,* United States Senior District Judge for the District of Nebraska

Judgment

This Cause came on to be heard on the record on appeal from the United States District Court for the District of Columbia, and was argued by counsel.

On Consideration Thereof It is ordered and adjudged by this Court that the judgment.....of the District Court appealed from in this cause is hereby affirmed, in accordance with the opinion of this Court filed herein this date.

Per Curiam
For the Court

/s/ Hugh E. Kline
Hugh E. Kline
Clerk

Date: September 6, 1974
Opinion for the Court filed by Circuit Judge Robb.

* Sitting by designation pursuant to 28 U.S.C. § 294(d).

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

September Term, 1974
Civil Action 547-72

No. 72-1789

Filed Oct. 17, 1974

Hugh E. Kline, Clerk

New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc., *Appellant*

v.

The Prudential Life Insurance Company of America, et al., *Appellee*

Before: Bazelon, Chief Judge; Robb, Circuit Judge and Van Pelt *, U.S. Senior District Judge for the District of Nebraska.

Order

On consideration of appellant's petition for rehearing, it is

ORDERED by the Court that appellant's aforesaid petition is denied.

Per Curiam
For the Court

/s/ HUGH E. KLINE
Hugh E. Kline
Clerk

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* Sitting by designation pursuant to Title 28 U.S. Code Section 294(d).

APPENDIX E

STATUTES AND REGULATIONS INVOLVED

Medicare Act

This reproduces pertinent sections of the Medicare Act from the 1970 codification in the *United States Code*, which version governs the issues presented here. Congress amended some of these sections in 1972. Pub. L. No. 92-603.

Section 1814(b) of the Medicare Act (42 U.S.C. § 1395f (b) (1970), *as amended*, 42 U.S.C. § 1395f(b) (Supp. II, 1972)) reads as follows:

> "The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be the reasonable cost of such services, as determined under section 1395x(v) of this title."

Section 1816 of the Medicare Act (42 U.S.C. § 1395h (1970), *as amended*, 42 U.S.C. § 1395h (Supp. II, 1972)) reads in relevant part as follows:

> "If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or

organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 426 of this title, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part."

Section 1861(v) of the Medicare Act (42 U.S.C. § 1395x (v) (1970), *as amended*, 42 U.S.C. § 1395x(v) (Supp. II, 1972)) reads in relevant part as follows:

"The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services . . . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in

computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers."

Section 1871 of the Medicare Act (42 U.S.C. § 1395hh (1970)) reads as follows:

"The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary."

Medicare Regulations

Section 405.401 of the Federal Health Insurance for the Aged Regulations (20 C.F.R. § 405.401) reads as follows:

"(a) Under the health insurance program for the aged, the amount paid to any provider of services—i.e., hospital, extended care facility, or home health agency—for the covered services furnished to beneficiaries is required by section 1814(b) and section 1833(a)(2) of the Social Security Act to be the "reasonable cost" of such services.

"(b) These principles of reimbursement and the related policies described in this subpart establish the guidelines and procedures to be used by institutional providers, fiscal intermediaries, and the Social Security Administration in determining reasonable cost.

"(c) The principles of reimbursement are to be applied on behalf of the program by public and private organizations and agencies acting as fiscal intermediaries in the payment of claims. These organizations and agencies are selected after nomination by groups or associations of hospitals. Extended care facilities

and home health agencies may similarly nominate such intermediaries. The fiscal intermediaries are responsible for paying the bills of beneficiaries for covered services received in participating hospitals and other institutions under the medicare program. A provider may deal directly with the Social Security Administration, in which case the same principles are to be used in making payment for services.

"(d) In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points. They offer certain alternatives and options designed to fit individual circumstances and to allow time for those providers who do not already collect the statistical and financial data necessary for the reporting of costs to develop the necessary records.

"(e) An important role of the fiscal intermediary, in addition to claims processing and payment, and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure them equitable payment under the program."

Section 405.451 of the Federal Health Insurance for the Aged Regulations (20 C.F.R. § 405.451) reads as follows:

"(a) *Principle.* All payments to providers of services must be based on the "reasonable cost" of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

"(b) *Definitions*—(1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The

regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

"(c) *Application.* (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provisions in title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institu-

tions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, *or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services)*, such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider." *

Administrative Procedure Act

Section 4 of the Administrative Procedure Act (5 U.S.C. § 553 (1970)) reads in relevant part as follows:

"(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

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* The portion italicized was added by 37 Fed. Reg. 10354 (May 20, 1972), subsequent to the commencement of this action. This change is not relevant to this case.

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

• • •

"(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. . . ."

Section 10(a) of the Administrative Procedure Act (5 U.S.C. § 702 (1970)) reads as follows:

"A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof."

Section 10(e) of the Administrative Procedure Act (5 U.S.C. § 706 (1970)) reads as follows:

"To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to section 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error."